PEEHIP

Optional Insurance Plans

Dental | Cancer | Hospital Indemnity | Vision

October 1, 2010

Administered by

Southland Benefit Solutions, LLC

Post Office Box 1250 • Tuscaloosa, Alabama 35403 • Telephone 205/343-1250
Fax 205/343-1239 • 1-800-476-0677 • www.SouthlandPEEHIP.com

DentaNet

is a Southland network of Participating
Dentists benefiting PEEHIP members

Here Are The Top 3 Reasons To Use One Of Our Participating Dentists:

1 **THEY SAVE YOU MONEY**

2 **THEY SAVE PEEHIP MONEY**

3 **THEY SAVE YOU & PEEHIP MONEY**

DentaNet is one of the largest independent dental networks in the State of Alabama.
The network is designed to save you money.
One important reason you purchase benefits is to save money.

For a listing of Statewide DentaNet providers, visit
www.SouthlandPEEHIP.com

FACT

DentaNet is the network of participating dentists designed to benefit PEEHIP members.

FACT

DentaNet is one of the largest dental networks in the state of Alabama.

FACT

By using DentaNet providers, PEEHIP members save money.

QUESTION: ARE YOU SAVING MONEY?

If you participate in the PEEHIP Dental Plan, you probably purchased dental insurance to save the money.

DentaNet providers are all over the state.
To find a participating DentaNet provider in your area,
visit www.SouthlandPEEHIP.com or call us,
toll-free, at 1-800-476-0677 today.
You'll be glad you did.

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The Public Education Employees' Health Insurance Program was established under provisions of Act 83-455 of the 1983 Alabama Legislature. The Act created the Public Education Employees' Health Insurance Board. The Board established a uniform plan of health insurance for employees. This plan includes four optional plans of insurance that are administered by Southland Benefit Solutions, LLC.

Each eligible employee has the opportunity to elect one or more optional coverage(s) provided by the Public Education Employees' Health Insurance Board.

All the optional coverage's provided by the State Allocated Funds shall be under the Public Education Employee's Health Insurance Board. The plan begins October 1 of each plan year.

There are four (4) optional plans to choose from (Dental - Cancer - Hospital Indemnity - Vision). This summary of optional plans available to you is designed to help you understand the individual plan you chose. This booklet replaces any previously issued information.

Notice of Appeal: In the event payment of a claim is denied by the Plan Administrator and the insured is of the opinion such denial was improper, the insured has the right of appeal. The appeal procedure is as follows:

(1) To appeal, the insured must submit a request for review, in writing, to the Plan Administrator within sixty (60) days from the date any writing is received by the insured from the Plan Administrator denying payment of a claim. This request must contain the specific reasons the insured contends claim denial was improper. Within the same time period, insured may submit any other evidence which insured contends supports his or her position.

(2) The Plan Administrator will review the claim; any written requests or other evidence received from the insured and advise the insured of its final determination.

(3) If the insured is still of the opinion that claim denial is improper, insured may obtain a judicial review of the Plan Administrator's decision by the Circuit Court of Montgomery, Alabama. This judicial review of contested cases is allowed under the Alabama Administrative Procedures Act, 41-22-20 of the Code of Alabama, 1975.

ALL THE TERMS, CONDITIONS, AND LIMITATIONS OF EACH PLAN ARE NOT COVERED HERE. ALL BENEFITS ARE SUBJECT TO THE TERMS, CONDITIONS, AND LIMITATIONS OF THE MASTER CONTRACT BETWEEN THE PUBLIC EDUCATION EMPLOYEES HEALTH INSURANCE BOARD AND YOUR PLAN ADMINISTRATOR. A COPY OF THE CONTRACT IS KEPT ON FILE AT THE PUBLIC EDUCATION EMPLOYEES HEALTH INSURANCE BOARD OFFICE AND IS AVAILABLE FOR YOU TO REVIEW. THE INFORMATION IN THIS BOOKLET IS NOT A SUBSTITUTE FOR THE LAW OR THE MASTER CONTRACT. IF A DIFFERENCE OF INTERPRETATION OCCURS, THE LAW GOVERNS. THE LAW MAY CHANGE AT ANY TIME ALTERING INFORMATION IN THIS HANDBOOK. THE BOARD RESERVES THE RIGHT TO CHANGE BENEFITS DURING THE PLAN YEAR.

October 1, 2010

GENERAL INFORMATION FOR ALL PLANS

"PLAN YEAR" means a period which begins October 1st through the next September 30th. This applies to all plans.

Eligible Employee:
Any person employed full-time in any public institution of public education K-14. Under certain conditions, employees of other institutions and agencies that participate in the Teachers' Retirement System of Alabama. Any eligible dependent as defined below.

Eligible Dependents are:

1. The employee's lawful spouse as defined by Alabama law. .
2. A married or unmarried child under the age of 26 if the child is your biological child, legally adopted child, foster child, or stepchild without conditions of residency, student status or dependency. A foster child is any child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
3. The eligibility requirements for any other children such as grandchildren must meet the same requirements as foster children and must be placed with you by decree or other order of any court of competent jurisdiction, for example, legal custody, legal guardianship. However, PEEHIP is not required and will not provide coverage for a child of a child receiving dependent coverage.
4. A dependent child of any age incapable of self-sustaining employment because of a physical or mental handicap who is also chiefly dependent on the employee for support. The handicap must have existed prior to the time the child attained age 26, and the child had to be covered as a dependent on your policy before reaching the age limit of 26. Proof of the child's condition and dependence must be submitted to PEEHIP within 45 days after the date the child would otherwise cease to be covered because of age. PEEHIP may, from time to time, require proof of the continuation of such condition and dependence. If the child is approved as an incapacitated child and allowed to stay on an optional plan, the child cannot change plans and be covered on other PEEHIP plans if he or she has already reached the limiting age of 26.

Aged Out:
When the dependent has attained the chronological age of 26, the child's coverage will terminate the first day of the month following his/her 26th birthday. Once an eligible dependent has "aged out", then such person is ineligible to participate in the plan again as a dependent except subsequently as the spouse of an eligible member.

Enrollment of Dependents:
Participating employees must enroll their eligible dependents under this plan by enrolling in the PEEHIP Member Online system or completing a paper enrollment form and submitting the form to the PEEHIP office within the specified deadline.

Required Documentation For Dependents:
Every member who has a dependent enrolled on his/her PEEHIP coverage(s) will be required to certify to PEEHIP their dependent's eligibility. Certification may require appropriate documents to support your dependent's eligibility. Such documents required will be a marriage certificate for a spouse; a declaration of marriage or proof of joint residence and joint financial records for a common law spouse; a birth certificate for a natural child; a certificate of adoption for an adopted child; a marriage certificate and the step child's birth certificate; a placement authorization for a foster child;
a court order signed by a judge appointing legal guardianship or legal custody for other children who are not biological, adopted or step children.

Ineligible Dependents:
Examples of ineligible dependents who are not eligible to be on your Optional plans include, but are not limited to, the following: ex-spouse; daughter-in-law or son-in-law; grandchildren or other children related to you by blood or marriage other than biological, adopted, foster or step-children for which you do not have legal guardianship or legal custody; children not related by blood or marriage to you for which you do not have legal guardianship or legal custody who are not foster children or adopted children.

If you are covering an ineligible dependent, you must notify PEEHIP and disenroll the dependent immediately. If you know of someone who is covering an ineligible dependent, please

notify PEEHIP by phone 877.517.0020, fax 877.517.0021, email peehipinfo@rsa-al.gov or mail PEEHIP, P.O. Box 302150, Montgomery, AL 36130-2150. Covering ineligible dependents unnecessarily raises costs for all eligible PEEHIP members. Help PEEHIP prevent fraud, waste and abuse through compliance with its dependent eligibility policies.

IF THE EMPLOYEE DOES NOT HAVE A DEPENDENT AT THE TIME OF COVERAGE, the employee must enroll for the dependents' benefits within forty-five (45) days of acquiring a new dependent. If the Public Education Employees' Health Insurance Board is notified within 45 days following date of marriage, birth, adoption, etc., the effective date will be the date of the coverage event. If notified later than 45 days after the person becomes a dependent, coverage of such person may not commence until the annual Open Enrollment period.

IF THE EMPLOYEE HAS DEPENDENT COVERAGE, the employee must enroll a new dependent(s) before any claims can be paid for the new dependent. No prior notification is required.

If confined in a hospital, nursing home, other health care institution, or at home under treatment of a physician, nurse, or other health service on the date the employee or the employee's dependent otherwise would become covered, coverage under this program shall not become effective until the date the employee or the employee's dependent ceases to be so confined in the hospital, nursing home, health care institution, or at home under the care of a physician, nurse, or health services.

Notwithstanding anything in this Plan to the contrary, **benefits for a newborn child shall not be paid until the newborn child ceases to be confined in the hospital or health care facility in which he was born or upon the fifteenth day of life, whichever first occurs.**

Change of Benefits:
The benefits in effect at the date of admission into the hospital or other covered health care facility of the employee or the employee's dependent will be the benefits payable until the date of discharge from the hospital or covered health care facility even though benefits under this program are changed during such confinement.

Insurance Commences:
Insurance commences upon the application of final approval by the administrative staff of the Public Education Employees' Health Insurance Program.

I.D. Card:
Will be provided by the Plan Administrator as quickly after enrollment as possible.

Claim Forms:
The Plan Administrator will provide claim forms at the central office of each system and on the Southland and PEEHIP websites.

Plan Administrator:
The Plan Administrator for the optional plans is Southland Benefit Solutions, LLC - P.O. Box 1250 - Tuscaloosa, Alabama 35403-1250. (1-800-476-0677)

PAYMENT AND CLAIM FILING LIMITATION:
All claims must be submitted in writing and such writing must be received by the Plan Administrator **no later than 365 days** following the date covered expenses are incurred. If a claim is not submitted and received by the Plan Administrator within this period, the claim for that benefit will not be paid.

Claim forms must be completed, with proper documentation and certification from the health care provider, upon submission. Failure to provide a completed claim form may cause delays in claims processing and may be cause for the denial of the claim.

Claim forms resubmitted in an effort to obtain coverage not normally provided will not be accepted and will be denied.

Termination of Coverages:
Coverage remains in effect through the last day of the month in which employment terminates or month of last payment due employee.
Coverage will be terminated in accordance with the applicable federal and state laws and regulations. Please see the section "Continuation of Coverage" in this brochure which outlines your rights under Public Law 99-272, Title X.

Enrollment:
Enrollment in any or all of the plans must continue through the end of the plan year.

Incorrect Benefit Payments:
Every effort is made to promptly and correctly process claims. If payments are made to you in error, or to a provider who furnished services or supplies to you, and the Plan Administrator later determines that an error has been made, you or the provider will be required to repay any overpayment. If repayment is not made, the Plan Administrator may deduct the amount of the overpayment from any future payment to you or the provider. If this action is taken, the Plan Administrator will notify you in writing.

Fraudulent Claims: Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

NOTWITHSTANDING ANYTHING IN THE PLAN SUMMARY OR THE MASTER PLAN TO THE CONTRARY, THE BENEFIT BOARD RESERVES THE RIGHT TO DENY COVERAGE OR PAYMENT FOR ANY CHARGE INCURRED BY A COVERED PERSON THAT WAS NOT MEDICALLY NECESSARY.

THERE IS NO COORDINATION OF BENEFITS FOR THE HOSPITAL INDEMNITY AND THE CANCER PLANS. THERE IS COORDINATION OF BENEFITS FOR THE DENTAL AND VISION PLANS; SPECIFICALLY, PEEHIP DENTAL AND VISION PLAN BENEFITS WILL BE SECONDARY TO ALL OTHER COVERAGES AVAILABLE TO ANY CLAIMANT. THE TOTAL AMOUNT THAT IS PAYABLE UNDER ALL PLANS WILL NOT BE MORE THAN 100% OF THE MAXIMIUM ALLOWABLE EXPENSES.

DENTAL BENEFITS PROGRAM

Plan Summary*

Dental Benefit Schedule

	Plan I (Employee Only)	Plan II (Employee & Full Family)
Maximum benefits applicable Per person per plan year:	$1,250.00	$1,000.00

Diagnostic & Preventive Services: Based on Reasonable & Customary Charges

Deductible	None	None
Oral Examinations	100%	100%
Cleaning of Teeth	100%	100%
Fluoride Applications for children	None	100%
Space Maintainers for children[1]	None	Limited
X-Rays	100%	100%
Emergency Office Visits	100%	100%
Sealants	None	100%

Basic & Major Services: Based on Reasonable & Customary Charges

Deductible[2]	None	$25.00
Fillings	80%	60%
General Anesthetics	80%	60%
Oral Surgery[3]	80%	60%
Periodontics	80%	60%
Endodontics	80%	60%
Dentures[4]	80%	60%
Bridgework[4]	80%	60%
Crowns	80%	60%

NO ORTHODONTIA BENEFITS

1 Space maintainers limited to $125.00 per unit

2 Deductibles are applied per person, per plan year with a maximum of three (3) per Family

3 Oral surgery excludes any procedures covered under a Group Medical Program

4 No benefits are provided for replacement of teeth removed before coverage is effective.

* Expenses are incurred at the preparation date and not the installation, service, or "Seating" date

* Benefits are not provided for temporary partials

COVERED DENTAL EXPENSES

Charges of a dentist or medical doctor which an employee is required to pay for services which are necessary for the diagnosis, prevention, or treatment of a dental condition, but only to the extent that such charges are reasonable and customary, and only if rendered in accordance with broadly accepted standards of dental practice.

Expenses are incurred at the preparation date and not the installation, service, or "seating" date.

The maximum benefits applicable per person, per plan year are Plan I (employee) $1,250.00, Plan II (employee and full family) $1,000.00.

REASONABLE AND CUSTOMARY CHARGES

The term "reasonable and customary charges" means the actual fee charged by a dentist in Alabama for a service rendered, but only to the extent the fee is reasonable, taking into consideration the following items:

The **Usual Fee** which the individual dentist in Alabama most frequently charges the majority of his patients for service rendered;

The **Prevailing Range of Fees** charged in the same areas by dentists in Alabama of similar training and experience for service rendered; and

Circumstances or Complications requiring additional time, skill and experience.

DIAGNOSTIC AND PREVENTIVE EXPENSES

This plan will pay all reasonable and customary charges for:

Oral Examinations and Office Visits, but not more than two (2) examinations or office visits in a plan year. An examination and office visit are synonymous for the purposes of this benefit. This

category includes procedures performed by a dentist that aid in making diagnostic conclusions about the oral health of the individual patient and the dental care required. This limitation would not apply to emergency office visits.

Prophylaxis includes cleaning and scaling of teeth, but not more than two (2) times in a plan year. Charges for this type of treatment performed by a licensed dental hygienist are also included if rendered under the supervision of a licensed dentist.

Topical Application of Fluoride. Benefits are provided to cover topical application of fluoride for two (2) treatments per plan year. Benefits are available to insured persons to age nineteen (19).

Space Maintainers are fixed or removable appliances designed to prevent adjacent and opposing teeth from moving, and/or that replace prematurely lost or extracted teeth. Coverage is for charges incurred to maintain existing space. Benefits are available to insured persons to age fourteen (14). Benefits are limited to One Hundred Twenty-Five ($125.00) Dollars per space maintainer unit. However, no benefits will be provided for replacement of lost space maintainer units or replacement of outgrown space maintainer units which have been prescribed during the same plan year.

X-Rays. Dental x-rays including full mouth x-rays, but not more than once in any 36 consecutive months. Supplementary bitewing x-rays, but not more than twice in a plan year.

Sealants. Pit and fissure sealants are the prophylactic application of composite resin material to cavity prone enamel pits and fissures. Benefits are provided for covered individuals to age nineteen (19). Limited to a one time basis, per tooth.

OTHER COVERED DENTAL EXPENSES

This plan will pay the percentage of reasonable and customary charges as shown in the Dental Benefit Schedule for the following:

Restorations (includes fillings, inlays, onlays, and crowns) treatment necessary to restore the structure of a tooth or teeth.

Benefits are provided for a replacement of gold or crown restoration if the restoration was installed while covered under this plan and at least five (5) years prior to this replacement.

Multiple restorations on one tooth will be paid on the same basis as a multiple surface restoration rather than as an individual restoration. Bonding will be considered equal to crowning with acceptance and replacement restrictions the same.

Endodontics. Procedures used for the prevention and treatment of diseases of the dental pulp and the surrounding structures.

General Anesthesia when medically necessary and administered in connection with oral surgery.

Periodontics. Procedures for the treatment of the gum and tissue supporting the teeth.

Oral Surgery. Procedures performed in or about the mouth which involve, but are not limited to, the incision and excision procedures for the correction of disease, injury or preparation of the mouth for dentures. Dental surgery includes charges for removal of teeth.

Prosthodontics. Services performed to replace one or more teeth except third molars (wisdom teeth), extracted while the patient is covered under the plan. The plan will not cover replacement of existing bridgework or dentures; however, the plan will cover the installation of a permanent full denture that replaces, or is installed within 12 months of a temporary denture, repairing or recementing inlays, crowns, bridgework, dentures or relining of dentures. The plan will also cover the replacement of an existing partial by a new partial; replacement of a full denture or bridgework; or the addition of teeth to an existing denture or bridgework, but only if:

A. The existing denture or bridgework was provided while coverage under this plan was in effect, the existing denture or bridgework is at least five (5) years old and cannot be made serviceable; or
B. The replacement or addition of teeth is required to replace one or more natural teeth extracted or accidentally lost while insured.

No benefits shall be provided under the plan for dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.

No benefits are provided for replacement of teeth removed before coverage is effective.

PRE-DETERMINATION OF BENEFITS

Before beginning a course of treatment for which dentists' charges are expected to be $150.00 or more, a description of the proposed course of treatment and charges to be made should be filed on the claim form with the Plan Administrator. The Plan Administrator will then determine the estimated benefits payable for Covered Dental Expenses expected to be incurred and advise the employee and the dentist before treatment begins. Services must be completed within a reasonable length of time from date predetermination was processed.

Emergency treatments, oral examinations including prophylaxis and dental x-rays are considered part of a course of treatment, but these services may be rendered before the Pre-Determination of Benefits procedure is begun.

A course of treatment is a planned program of one or more services or supplies whether rendered by one or more dentists for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

After the course of treatment is completed, the Plan benefit shall be paid in accordance with the final claim submitted by the dentist. In the event of any change in the final claim or treatment, the Plan Administrator shall adjust payment accordingly. In the event the dentist makes a major change in the treatment plan, the dentist should send in a revised plan.

In the event there is no claim for a predetermination of benefits, the benefit will be paid based upon the information submitted to the Administrator of the Plan at the time of the claim.

ALTERNATE PROCEDURES

When it is determined that several methods of treatment exist to treat a particular problem, then benefits will be paid based on the least costly scheduled amount so long as the result meets generally acceptable dental standards. Unless prior written consent is received from the Plan Administrator, dental benefits are limited to the least costly procedure.

COORDINATION OF DENTAL BENEFITS

If an enrolled member is covered under more than one group dental plan or is entitled to any other source, the total amount that is payable under all plans will not be more than 100% of the maximum allowable expenses. **PEEHIP dental benefits will be secondary to all other dental coverages available to a claimant.**

DENTANET BENEFITS

The dental coverage administered by Southland will offer a dental network to members and dependents enrolled in the dental plan. Under the Southland dental network, known as "DentaNet", MEMBERS HAVE THE OPPORTUNITY TO USE THE NETWORK DENTISTS BUT STILL HAVE THE FREEDOM TO USE ANY DENTIST. DentaNet dentists cannot balance bill you for the difference between the negotiated fee schedule and what they normally charge. On services requiring you to pay a coinsurance fee, the coinsurance payment will be based on a negotiated fee. PEEHIP and its members save money when DentaNet dentists are used. You may obtain a list of DentaNet dentists from the Southland website, www.southlandpeehip.com.

EXTENSION OF DENTAL BENEFITS

Even though the coverage for an enrolled member has terminated, he will be entitled to extended coverage for the purpose of the completion of any dental service for which a treatment plan has been approved by the administrator, provided that the services are completed within 30 days of such approval.

DENTAL EXCLUSIONS

No benefits are payable for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan.
2. Replacement of teeth removed before coverage is effective.
3. Work done for appearance (cosmetic) purposes. Facing on crowns and pontics posterior to the second bicuspid, are always considered to be cosmetic.
4. Work done while not covered under this plan.
5. Services or supplies in connection with orthodontia except for extractions.
6. Extra sets of dentures or other appliances.
7. Broken appointment.
8. Replacing lost or stolen prosthetic appliances.
9. Completion of claim forms or filing of claims.
10. Educational or training programs, dietary instructions, plaque control programs, and oral hygiene information.
11. Implantology (implants).
12. Periodontal splinting.
13. Work covered under the group hospital medical indemnity plan.
14. Experimental procedures.
15. Drugs or their administration.
16. Anesthetic services billed by anyone other than the attending dentist or his assistant.
17. Services and supplies not ordered by a dentist or physician and not reasonably necessary for treatment of injury or dental disease.
18. Appliances, restorations, and procedures to alter vertical dimension including, but not limited to, harmful habit appliances.
19. Services or supplies that exceed the reasonable and customary charges in Alabama.
20. Treatment of an accident related to employment or sickness if either or both are covered under Workmen's Compensation or similar laws.
21. Work that is otherwise free of charge to patients or charges that would not have been made if there were no insurance.

22. Work that is furnished or payable by the Armed Forces of any government.
23. Services or supplies furnished by the United States, state or local government.
24. Services received for injuries or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan.
25. Expenses to the extent of benefits provided under any employer group plan other than this plan in which the State of Alabama participates in the cost thereof.
26. Such other expenses as may be excluded by regulations of the board.
27. Gold foil restorations.
28. Pulp capping or acid etching as a separate procedure.
29. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
30. Periodontal cleaning aids or devices.
31. Specific charges for infection control and/or protection supplies, including but not limited to, gloves, masks, gowns, shoes or other items.
32. Microscopic bacteriological examinations.
33. Antimicrobial irrigation.
34. Temporomandibular joint (TMJ) disorders.
35. Benefits are not provided for temporary partials.
36. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider.
37. All claims must be submitted in writing, completed, with the requisite certification of the health care provider, and received by the Plan Administrator no later than 365 days following the claim incurrence.
38. Services of a dentist who is related to the member by blood or marriage or who regularly resides in the same household.
39. Hospital expenses for dental work performed in the hospital.

CANCER PROGRAM
Coverage Outline

A. **Hospital Confinement:** $250.00 per day for first 90 consecutive days of hospital confinement for in-patient charges; $500.00 per day thereafter. Readmission 30 days after discharge starts $250.00 daily payment again. No limit on number of confinements or dollar amount.

In-Hospital Benefits (per day) under this plan do not cover charges for out-patient or same-day surgery UNLESS you are admitted on an in-patient basis where you are charged for a private or semi-private room. Emergency Room, Out-patient Room, Observation Room, or a similar type room is not to be considered as a private or semi-private room and benefits are not provided for such charges under this plan.

B. **Hospice Care:** Actual charges to a maximum of $50.00 per day for care provided by a licensed Hospice agency, organization or unit that provides to persons terminally ill, and to their families, a centrally administered and autonomous continuum of palliative and supportive care. The care must be directed and coordinated by the Hospice organization in the patient or family home. This benefit does not apply to non-terminally ill patients, nor does it apply to home health care or custodial care benefits. Lifetime maximum of $3,000 per insured.

C. **Cancer Surgery:** Actual charges for operation depending on type of surgery (see schedule of policy), to a maximum of $2,400.00. Hospitalization not required. No limit on number of operations.

D. **Anesthesia:** Actual charges to a maximum of $400.00 per operation. No limit on number of operations.

E. **Radiation & Chemotherapy:** Actual charges to a lifetime maximum of $10,000.00 for Cobalt Therapy, X-Ray Therapy or Chemotherapy Injections. Hospitalization not required. Diagnostic tests not included.

F. **Blood & Plasma:** Actual charges to a lifetime maximum of $2,000.00. Includes transfusions, administration, processing and procurement, and cross-matching (excludes other laboratory expenses). Hospitalization not required. No lifetime maximum for Leukemia.

G. **Nursing Service:** Actual charges for full-time private care and attendance to $80.00 per day for R.N., L.P.N., or L.V.N. for each day the insured is eligible for Hospital Confinement Benefit. Such services to be rendered by a person who does not ordinarily reside in the same household with the covered person, and who is not related by blood, marriage or legal adoption to the covered person. No lifetime maximum.

H. **Attending Physician:** Actual charges to a maximum of $20.00 per day for physician other than the surgeon for each day the insured is eligible for Hospital Confinement Benefit. No lifetime maximum.

I. **Prosthetic Devices:** Actual surgery charges to a maximum of $500.00 for each surgically implanted prosthetic device for which is prescribed as a direct result of cancer surgery. Lifetime maximum of $1,000.00 per insured.

J. **Ambulance:** Actual charges to a maximum of $100.00 per trip to and from hospital where insured is confined as an in-patient. Limit two trips per confinement. No lifetime maximum.

SCHEDULE OF OPERATIONS:
(Maximum Amounts Payable)

If two or more surgical procedures are performed by the same surgical approach or in the same operative field, the amount paid by the Plan will be that of the more expensive of the two procedures performed.

ABDOMEN:	
Paracentesis	100.00
Exploratory laporatomy	600.00
Cholecystectomy	800.00
BLADDER:	
Cystoscopy	150.00
Cystectomy	
(Partial)	1,000.00
(Complete)	1,800.00
TUR bladder tumors	600.00
BRAIN:	
Exploratory Craniotomy	1,200.00
Burr holes not followed by surgery	300.00
Excision brain tumor	2,400.00
BREAST:	
Needle Biopsy	150.00
Cutting Operation Biopsy	300.00
Mastectomy	
(Simple)	800.00
(Radical)	1,200.00
Lumpectomy	400.00
CERVIX:	
D&C	200.00
Colposcopy	200.00
Abdominal and Vaginal Hysterectomy/uterus only	800.00
Uterus, tubes, & ovaries	1,200.00
CHEST:	
Thoracentesis	100.00
Bronchoscopy	300.00
Mediastinoscopy	300.00
Thoracostomy	800.00
Pneumonectomy	1,600.00
Wedge Resection	1,200.00
Lobectomy	1,400.00
ESOPHAGUS:	
Esophagoscopy	300.00
Resection of Esophagus	1,600.00
Esophagogastrectomy	1,400.00
EYE:	
Enucleation	400.00
P32 uptake	200.00
INTESTINES:	
Sigmoidoscopy	150.00
Proctosigmoidoscopy	150.00
Colonoscopy	300.00
Cutting Operation of rectum for biopsy	300.00
Colostomy/or revision of	400.00
Heostomy	400.00
Colectomy	1,000.00
Abdominal-Perineal approach for removal of cancer of sigmoid colon or rectum	2,000.00
Resection small intestine	2,000.00
KIDNEY:	
Nephrectomy	2,000.00
LIVER:	
Needle Biopsy	150.00
Wedge Biopsy	300.00
Resection of liver	1,000.00
LYMPHATIC:	
Excision of lymph node	200.00
Splenectomy	800.00
Axillary node dissection	800.00
Lymphadenectomy	
(Unilateral)	800.00
(Bilateral)	1,000.00
MANDIBLE:	
Mandibulectomy	1,600.00

MISCELLANEOUS:

Bone Marrow Biopsy or Aspiration	150.00
Pathological Fracture Hip	1,000.00

MOUTH:

Hemiglossectomy	400.00
Glossectomy	800.00
Resection of Palate	800.00
Tonsil/Mucous membrane	600.00

PANCREAS:

Jejunostomy	1,000.00
Pancreatactomy	2,400.00
Whipple Procedure	2,400.00

PENIS:

Amputation	
(Partial)	300.00
(Complete)	600.00
(Radical)	800.00

PROSTATE:

Cystoscopy	150.00
TUR Prostate	600.00
Radial Prostatectomy	1,400.00

SALIVARY GLANDS:

Biopsy	400.00
Partidectomy	800.00
Radial Neck Dissection	1,600.00

SKIN:

Excision of lesion of skin	150.00
With flap or graft	400.00

SPINE:

Laminectomy	1,000.00
Cordotomy	600.00

STOMACH:

Gastroscopy	300.00
Partial Gastrectomy	1,000.00
Gastrectomy	1,400.00
Gastrojejunostomy	1,000.00

TETIS:

Orchiectomy	400.00

THROAT:

Laryngoscopy	300.00
Laryngectomy	
(Without neck dissection)	800.00
(With neck dissection)	1,600.00
Tracheostomy	300.00

THYROID:

Thyroidectomy	
Partial (one lobe)	600.00
Total (both lobes)	800.00

VULVA:

(Partial)	600.00
(Radical)	1,200.00

LIMITATIONS AND EXCLUSIONS

A. This Policy pays only for loss resulting from hospitalization for definitive cancer treatment including direct extension, metastatic spread or recurrence. Pathologic proof must be submitted to support each claim. This policy does not cover any other disease, sickness or incapacity, and benefits are not provided for premalignant conditions, with malignant potential, or human immunodeficiency virus.

B. No benefits are payable for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the plan;
2. Hearing aids and examinations for the prescription or fitting of hearing aids;
3. Cosmetic surgery or treatment, specifically but not limited to, coverage for reconstruction surgery. However, there are limited benefits available for a surgically implanted prosthetic device which is prescribed as a direct result of cancer surgery. Please see Provision I. under Coverage;
4. Benefits are not paid for treatment in a United States government hospital unless the covered individual is actually charged for the treatment and is legally required to pay such charge;
5. Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan;
6. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;
7. Expenses to the extent of benefits provided under any employer group plan other than this plan in which the State of Alabama participates in the cost thereof;
8. Such other expenses as may be excluded by regulations of the Board;
9. Expenses due to Convalescent Long Term Care, Nursing

Home confinement or rehabilitation (the recovery of health and strength after disease, sickness or injury);

10. All claims must be submitted in writing, completed, with the requisite certification of the health care provider, and received by the Plan Administrator no later than 365 days following the claim incurrence;
11. Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

DEFINITIONS

A. **Cancer Defined - Positive Pathology Required**
Cancer is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, or leukemia.

Such cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology to practice Pathologic Anatomy, or an Osteopathic Pathologist. Diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or post-mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis does not meet this standard.

B. **Hospital Defined**
Hospital means a lawfully operating institution engaged mainly in providing treatment for sick or injured persons on an inpatient basis at the patient's expense. The treatment must be under the supervision of a licensed physician. The hospital must maintain diagnostic and therapeutic facilities on premise for surgical and medical treatment of such persons. These facilities must be supervised by a staff of legally qualified physicians and must include a laboratory, x-ray equipment and operating room. Permanent, full-time facilities for the care of overnight resident bed patients must be maintained. The patient's written history and medical records must

be kept on the premises. The hospital must have surgical facilities on premises where major surgery is performed on a regular routine basis. The hospital must be approved by the Joint Commission on the Accreditation of Hospitals, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities. Hospital does not include the institution, or part thereof, used as: a Hospice unit including any beds designated as a Hospice; a swing bed; a convalescent home; a rest home; a rest or nursing facility; pain clinic; psychiatric unit; rehabilitation unit; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or treatment for persons suffering from mental disease or disorders, care for the aged, drug and/or substance addicted or alcoholics.

Hospital Indemnity Program
Plan Summary Coverage

	Plan I (Employee Only)	Plan II (Employee/Family)
*In hospital benefit (per day) [1]	150.00	75.00
*Maternity (per day)	150.00	75.00
*Intensive care Benefit (per day)	300.00	150.00
*Convalescent or long Term care /Rehabilitation (per day) [2]	150.00	75.00
Supplemental accident[3]	1000.00	1000.00
Ambulance Benefit[4]	100.00	100.00

*In-hospital, Maternity, intensive care and convalescent or long term care benefits are exclusive and non duplicating

1. In hospital benefits are limited to 365 days per covered accident or illness; benefits will be paid for any admission on an in-patient basis where charges are incurred for a private or semi-private room.

2. limited to 90 days lifetime maximum

3. Limited to $1,000.00 per plan participant and/or dependent, per plan year

4. Ambulance benefits: limited to the amount of actual charges to a maximum of $100.00 per trip to or from a hospital where the insured is confined as an in-patient. No lifetime maximum.

DEFINITIONS

Convalescent or Long Term Care Facility is an institution which is used primarily as a rest facility, nursing facility or facility for the aged or for rehabilitation (the recovery of health and strength after disease, sickness or injury). Convalescent care may include home confinement. In no event, however, shall a convalescent or long term care facility include any institution which is a hospital as defined in this policy, or any institution primarily used for the care and treatment of drug addicts, alcoholics, and/or mental or nervous disorders or a hospice facility. Assisted living facilities are not covered by this plan and benefits will not be provided.

Convalescent or Long Term Care Facility Confinement Coverage or Home Confinement Coverage is provided for a lifetime maximum of ninety (90) days in the aggregate for payment of nursing care services. These benefits are payable only if all the following criteria are met:

A. The attending physician certifies that 24 hour nursing care by a Registered Graduate Nurse or Licensed Practical Nurse is medically necessary for recuperation.
B. The convalescent or long term care facility confinement is preceded by at least three consecutive days of hospital confinement for which benefits were payable.
C. It is due to the same sickness or injury and commences within 14 days after a previous hospital, convalescent or long term care facility confinement for which benefits were payable.
D. The condition of the Plan Participant or dependent requires twenty-four (24) hour a day nursing services by Registered Graduate Nurses or Licensed Practical Nurses, such services to be rendered by a person who does not ordinarily reside in the same household with the covered person, and who is not related by blood, marriage or legal adoption to the covered person.

Hospital means a lawfully operating institution engaged mainly in providing treatment for sick or injured persons on an inpatient basis at the patient's expense. The treatment must be under the supervision of a licensed physician. The hospital must maintain diagnostic and therapeutic facilities on premises for surgical and medical treatment of such persons. These facilities must be supervised by a staff of legally qualified physicians and must include a laboratory, x-ray equipment and operating room. Permanent, full-time facilities for the care of overnight resident bed patients must be maintained. The patient's written history and medical records must be kept on the premises. The hospital must have surgical facilities on premises where major surgery is performed on a regular routine basis. The hospital must be approved by the Joint Commission on the Accreditation of Hospitals, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

Hospital does not include the institution, or part thereof, used as: a Hospice unit including any beds designated as a Hospice; a swing bed; a convalescent home; a rest home; a rest or nursing facility; pain clinic; psychiatric unit; rehabilitation unit; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or treatment for persons suffering from mental disease or disorders, care for the aged, drug and/or substance addicted or alcoholics.

In-Hospital Benefit - In-Hospital Benefits (per day) under this plan do not cover charges for out-patient or same-day surgery UNLESS you are admitted on an in-patient basis where you are charged for a private or semi-private room. Emergency Room, Out-patient Room, Observation Room, or a similar type room is not to be considered as a private or semi-private room and benefits are not provided for such charges under this plan.

Injury means an accidental injury of the insured or dependent sustained while this policy is in force.

Mental/Nervous Disorder/Addiction Treatment: Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathy, psychosis, chemical imbalance or mental or emotional disease or disorders of any kind, including treatment for alcoholism and/or drug addiction. **Benefits for treatment of mental or nervous disorders and alcoholism and/or drug addiction treatment are limited to a maximum of 14 days confinement in a Hospital as an in-patient per plan year;** provided, however, the facility is not required to include a laboratory, x-ray equipment or an operating room.
Alcoholism and/or drug addiction treatment is further limited to a maximum of one admission of not more than 14 days confinement as an in-patient per plan year. This benefit is further limited to a lifetime maximum of two (2) admissions of not more than 14 days per admission for the treatment of substance abuse.

Supplemental Accident Benefit - this benefit will pay incurred expenses up to the benefit amount shown, when an insured sustains injury as a result of an accident if such injury **does not**

result in hospital confinement during the period ending one year from the date of such accident, and such injury is incurred while the coverage is in force and within 90 days of the date of such accident. Benefits will be limited to a maximum of $1,000.00 per plan participant and/or dependent, per plan year.

Inclusive in the $1,000.00 maximum benefit per participant and/or dependent, per plan year, are covered charges due to, or for, treatment of accidental injury by adjustment or manipulation of the spine or soft tissues, including but not limited to analysis, related x-ray and laboratory examinations, and related support, immobilization, and physical therapy procedures, include only those made by or on behalf of Qualified Practitioners and are limited to a maximum of:

1. $25.00 per visit;
2. Two visits in any seven consecutive days (all accidental injuries and Qualified Practitioners combined);
3. Thirty visits per plan year (all accidental injuries and Qualified Practitioners combined).

Accidental Injury means all such injuries of a covered person occurring while this plan is in force and caused by an external, violent force that was not expected, could not have been reasonably foreseen and was unrelated directly or indirectly to all other causes.

Qualified Practitioners are any duly licensed physicians operating within the scope of their license, including podiatrist, and doctors of chiropractic.

EXCLUSIONS

No benefits are payable for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan;
2. Hearing aids and examinations for the prescription or fitting thereof;
3. Cosmetic surgery or treatment, except to the extent necessary for correction of damage caused by accidental injury while

covered by the plan or as a direct result of disease covered by the plan;

4. Benefits are not paid for treatment in a United States government hospital unless the covered individual is actually charged for the treatment and is legally required to pay such charge;
5. Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan;
6. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;
7. Expenses to the extent of benefits provided under any employer group plan other than this plan in which the state participates in the cost thereof;
8. Such other expenses as may be excluded by regulations of the Board;
9. Outpatient or same-day surgery for illness is not a covered charge
10. Expenses or charges for emergency rooms, outpatient rooms, same-day surgery rooms, observation rooms, or similar type rooms
11. Dental treatment as a result of any cause, whether accidental or non-accidental.
12. All claims must be submitted in writing, completed, with the requisite certification of the health care provider, and received by the Plan Administrator no later than 365 days following the claim incurrence.
13. Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

Vision Program
Coverage and maximum benefits

Examination actual charges not to exceed:	40.00
Lenses not to exceed:	
Single Vision	50.00
Bifocals	75.00
Trifocals	100.00
Lenticular	125.00
Contacts	100.00
Frames	60.00

* Plan provides either contact or lenses and frames, but not both in any plan year.
** It is the responsibility of the member to submit a claim for either lenses or contacts and the payment will be made based on the date the claim is received.

LIMITATIONS

Examinations: One in any Plan Year.

Lenses: One new prescription or replacement in any Plan Year. Benefits are not available under the plan for both lenses and contacts in the same Plan Year.

Contacts: One new prescription or replacement in any Plan Year. Plan provides either contacts or lenses and frames, but not both in any Plan Year.

Frames: One new or replacement in any Plan Year.

Vision Examination: Consisting of one or more, but not limited to the following component services when performed by a licensed ophthalmologist or optometrist.

* case history
* external examination of the eye and adnexa
* determination of refractive status
* ophthalmoscopy

* application of pharmaceutical agents for diagnostic purposes when indicated and allowed by state law
* tonometry test for glaucoma when indicated
* binocular measure
* summary findings and recommendations
* prescribing corrective lenses, if needed

DEFINITIONS

Bifocal Lenses: Lenses containing 2 foci (points of convergence of rays of light), usually arranged with the focus for distance above and a smaller segment for near focus below.

Trifocal Lenses: Lenses containing 3 foci, usually arranged with the focus for distance above, for intermediate distance in the middle, and for near vision below.

Lenticular Lenses: Special non-contact lenses for persons who have cataracts.

Contact Lenses: Lenses which fit directly on the eyeball under the eyelids.

Frames: A standard eyeglass frame into which two lenses are fitted.

Ophthalmologist: A licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of his or her license, performs vision examinations, prescribes lenses to improve visual acuity, and performs surgical procedures to the eye.

Optometrist: Any doctor of optometry legally qualified to practice optometry in the state in which Vision Care services are rendered, who performs vision examinations and prescribes lenses to improve visual acuity.

Optician: A person qualified in the state in which the service is rendered to supply eye-glasses according to prescriptions written by an ophthalmologist or optometrist, to grind or mold lenses or have them ground or molded according to prescription, to fit them

into a frame and to adjust the frame to fit the face.

Lens or Lenses: Ophthalmic corrective lens or lenses, glass or plastic, ground or molded, as prescribed by an ophthalmologist or optometrist, to be fitted into a frame.

EXCLUSIONS

Vision Care Plan benefits will not be provided for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan;
2. Services or supplies for which coverage is provided or available under any other medical benefit program maintained by the Public Education Employees' Health Insurance Board, or by Workers' Compensation Laws, or by any Safety Lens program;
3. Drugs or any other medication;
4. Any medical or surgical treatments;
5. Special or unusual treatment such as orthoptics, vision training, sub-normal vision aids, aniseikonia lenses or tonography;
6. Services or supplies not prescribed by a licensed physician, optometrist, or ophthalmologist, and lenses which do not require a prescription;
7. Service or supplies which are experimental in nature or are not approved by the American Ophthalmology Association;
8. The extra charge for oversized, photo sensitive, or anti-reflective lenses, whether or not medically necessary;
9. Sun glasses, including lenses and frames;
10. Follow-up visits, fitting fees, dispensing fees, coating or care kits;
11. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;
12. All claims must be submitted in writing, completed, with the requisite certification of the health care provider, and received by the Plan Administrator no later than 365 days following the claim occurrence.

13. Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

COORDINATION OF VISION BENEFITS

If an enrolled member is covered under more than one group vision plan or is entitled to any other source, the total amount that is payable under all plans will not be more than 100% of the covered expenses. PEEHIP benefits will be secondary to all other coverages available to a claimant

CONTINUATION COVERAGE FOR ALL PLANS

--- VERY IMPORTANT NOTICE ---

Federal Law requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. (Both you and your spouse should take time to read this notice carefully.)

If you are an employee of Public Education in Alabama (the "Employer") covered by the Public Education Employees' Health Insurance Plan (the "Plan"), you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes eligible for Medicare.

In the case of a dependent child of an employee covered by the Plan, he or she has the right to continuation coverage if group health coverage under the plan is lost for any of the following five reasons:

1. The death of a parent;
2. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's

hours of employment with the Employer;
3. Parents' divorce or legal separation;
4. A parent becomes eligible for Medicare; or
5. The dependent ceases to be an eligibile child under the Plan.

Under COBRA, the employee, ex-spouse or a family member has the responsibility to inform the Public Education Employees' Health Insurance Board (PEEHIB) that he or she desires continuation of coverage within 60 days of a divorce, legal separation, or a child losing eligibility under the Plan and must obtain a *Continuation of Coverage Application* Form. PEEHIP may be notified by phone or in writing. The Employer has the responsibility to notify the PEEHIB of the employee's death, termination of employment or reduction in hours, or Medicare eligibility.

When the PEEHIB is notified that one of these events has happened and that the employee or dependent desires continuation of coverage, the PEEHIB will in turn notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the date you would lose coverage because of one of the events described above to inform the PEEHIB that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance coverage will end on the last day of the month in which you become ineligible.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months.
However, the law also provides that your continuation coverage may be cut short for any of the following five reasons:

1. PEEHIP no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid by the member when payment is due, or the premium payment is insufficient;
3. The member becomes covered under another group health plan, which does not contain any exclusions or limitations with respect to any preexisting condition;
4. The member or dependent becomes entitled to Medicare after COBRA benefits begin; or
5. The member becomes divorced from a covered employee and subsequently remarries and is covered under the new spouse's group health plan, which does not contain any exclusions or limitations with respect to preexisting conditions.

An eligible member does not have to show that he/she is insurable to choose continuation of coverage. However, under COBRA law, he/she is required to pay the full COBRA monthly premium for continuation of coverage.

The address of the Public Education Employees' Health Insurance Board is
201 South Union Street, Montgomery, AL 36130-2150

PEEHIP
Southland Benefit Solutions, LLC
P.O. Box 1250
Tuscaloosa, Alabama 35403-1250